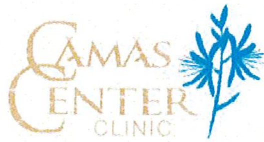

1821 N. LeClerc Road #1
Cusick, WA 99119
509-447-7111
Medical Records FAX 509-445-5020

CONSENT/ AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name:____ DOB: ________________
LAST FIRST MI

I hereby Consent and Authorize Camas Center Clinic To:

Initial at least one

___ ***Send*** a copy of my specific health information to person or organization named below
___ ***Receive*** a copy of specific health information from person or organization named below
___ ***Orally*** exchange specific health information with person or organization named below

Agency Name: ____
Address: ______________________________ **City:** __________ **State:** __________
Telephone: ____________________ **Fax:** ____________________

CONSISTING OF (check all that applies):
___ **Last Year's Medical Record**
___ **Most Recent**
___ **Other:**____

FOR THE PURPOSE OF: *(describing the purpose of disclosure)* ☐ Continuing Care; ☐ Other:
____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand that the records produced may be protected under federal regulations governing confidentiality, 42 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in this regulation. **I agree to the release of the information initialed below.**

____**HIV/AIDS and STD information**
____**Mental health services/psychotherapy**
____**Drug/alcohol treatment or rehabilitation**

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol treatment or rehabilitation.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when we have taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to: Privacy Officer, Camas Center Clinic, 1821 N LeClerc RD # 1, Cusick, WA 99119 and state that you are revoking this authorization.

You do not need to sign this authorization. Refusal to sign this authorization will not adversely affect you ability to receive health care or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care is solely for the purpose of providing health information to someone else and the authorization is necessary for you to make that disclosure.

I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or specify ________.

Signature ____________________ **Date** ______________ **Phone Number** __________

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